

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARYS b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 02833 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47-3 d. STREET ADDRESS 646 D.ST.N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LESLIE FRANCIS ABELL First Middle Last | | 4. DATE OF DEATH FEBURARY 1 1966 Month Day Year | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MARCH 27, 1900 9. AGE (In years last birthday) 65 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY US CIVIL SERVICE | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 13. FATHER'S NAME JACKSON B. ABELL | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. MRS. EDNA J. ABELL | |
| 17. INFORMANT 646 D.ST.N.E. WASHINGTON, D.C. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE WM.D. BOYD M.D. | | 22. DATE SIGNED 2/4/66 | |
| EXAMINER'S NAME (Type) WM.D. BOYD M.D. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | |
| 23b. DATE THEREOF 2/5/66 | | 23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEM. | |
| 23d. LOCATION (City, town or county) (State) LEONARDTOWN, MARYLAND | | 24. GENERAL DIRECTOR P.B. ROBINSON - LEONARDTOWN, MARYLAND | |
| 25a. REC'D BY REGISTRAR DATE FEB 7 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02834

CERTIFICATE OF DEATH

02805

| | | | | | | | |
|---|------------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | c. LENGTH OF STAY IN 1b 13 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MADDOX | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH HENRY ARMSTRONG | | | | 4. DATE OF DEATH Month Day Year FEBRUARY 13 1966 | | | |
| 5. SEX MALE | 6. COLOR OR RACE COLORED | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH AUG. 15, 1906 | | 9. AGE (In years last birthday) 59 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARMING | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JENKINS ARMSTRONG | | | | 14. MOTHER'S MAIDEN NAME ELLA BARBER | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 213-22-0254 | | 17. INFORMANT FRANCIS G. SWANN, | | Address MADDOX, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Carotid DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatous DUE TO (c) Ca of return | | | | | | INTERVAL BETWEEN ONSET AND DEATH 14h 3 hrs 1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from out , 19 57 , to Feb , 19 66 , that (I) (we) last saw the deceased alive on 12 Feb , 19 66 , and that death occurred at 12 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 2/14/66 | |
| 22c. PHYSICIAN'S NAME (Type) [Name] | | | | 22d. ADDRESS MECHANICSVILLE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF FEB. 16, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART | | 23d. LOCATION (City or Town) (County) (State) BUSHWOOD, MD. | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | | | 25a. REC'D BY REGISTRAR DATE FEB 17 1966 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 Film G374 3/7/66 mh

02835

CERTIFICATE OF DEATH

02807

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|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Saint Mary's</i> <i>Maryland</i> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>St. Mary's</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LEONARDTOWN</i> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Saint Mary's Nursing Home</i> | | | | d. STREET ADDRESS <i>411149th St. Inigoes</i> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Essie</i> First <i>Cordelia</i> Middle <i>Ball</i> Last | | | | 4. DATE OF DEATH <i>Feb</i> <i>25</i> <i>1966</i> | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>Cauc</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>8-15-93</i> | |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <i>Saint George's, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Benjamin Ball</i> Address <i>Saint George's, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio sclerotic Heart Disor.</i> DUE TO (c) <i>15 year</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Feb 21</i> , 1966 to <i>Feb 21</i> , 1966, that (I) (we) last saw the deceased alive on <i>25 Feb</i> 1966 and that death occurred at <i>7p</i> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Ernest D. Rehm</i> | | | | 22b. DATE SIGNED <i>28 Feb 66</i> | | 22c. PHYSICIAN'S NAME (Type) <i>Ernest D. Rehm, M.D.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 23b. DATE THEREOF <i>March 1, 1966</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Church Cemetery</i> | |
| 24. FUNERAL DIRECTOR <i>Alfred L. McCombs</i> | | | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

02836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02806

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | c. LENGTH OF STAY IN 1b DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL | | | | d. STREET ADDRESS Rt. 1 Box 13A26 | | | |
| 3. NAME OF DECEASED (Type or print) First DAVID Middle BENNETT Last BENNETT | | | | 4. DATE OF DEATH FEBRUARY 15, 1966 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE COLORED | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH FEB. 2, 1911 | |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months 15 Days 19 | | IF UNDER 24 HRS. Hours 66 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME WILLIE BENNETT | | | | 14. MOTHER'S MAIDEN NAME ROXANNA JAMES BENNETT | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT SAVANNAH MRS. BENNETT Address SAME AS # 2 ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cerebral hemorrhage 443X DUE TO Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Rudiger Breiteneker, M.D. EXAMINER'S NAME (Type) | | | | 22. DATE SIGNED 2-16-66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF FEB. 19, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY HOUSE OF GOD AND PRAYER | | 23d. LOCATION (City or Town) (County) (State) PARK HALL, MARYLAND | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | 25a. REC'D BY REGISTRAR FEB 21 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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Page 4 may be retained by the hospital or attending physician.

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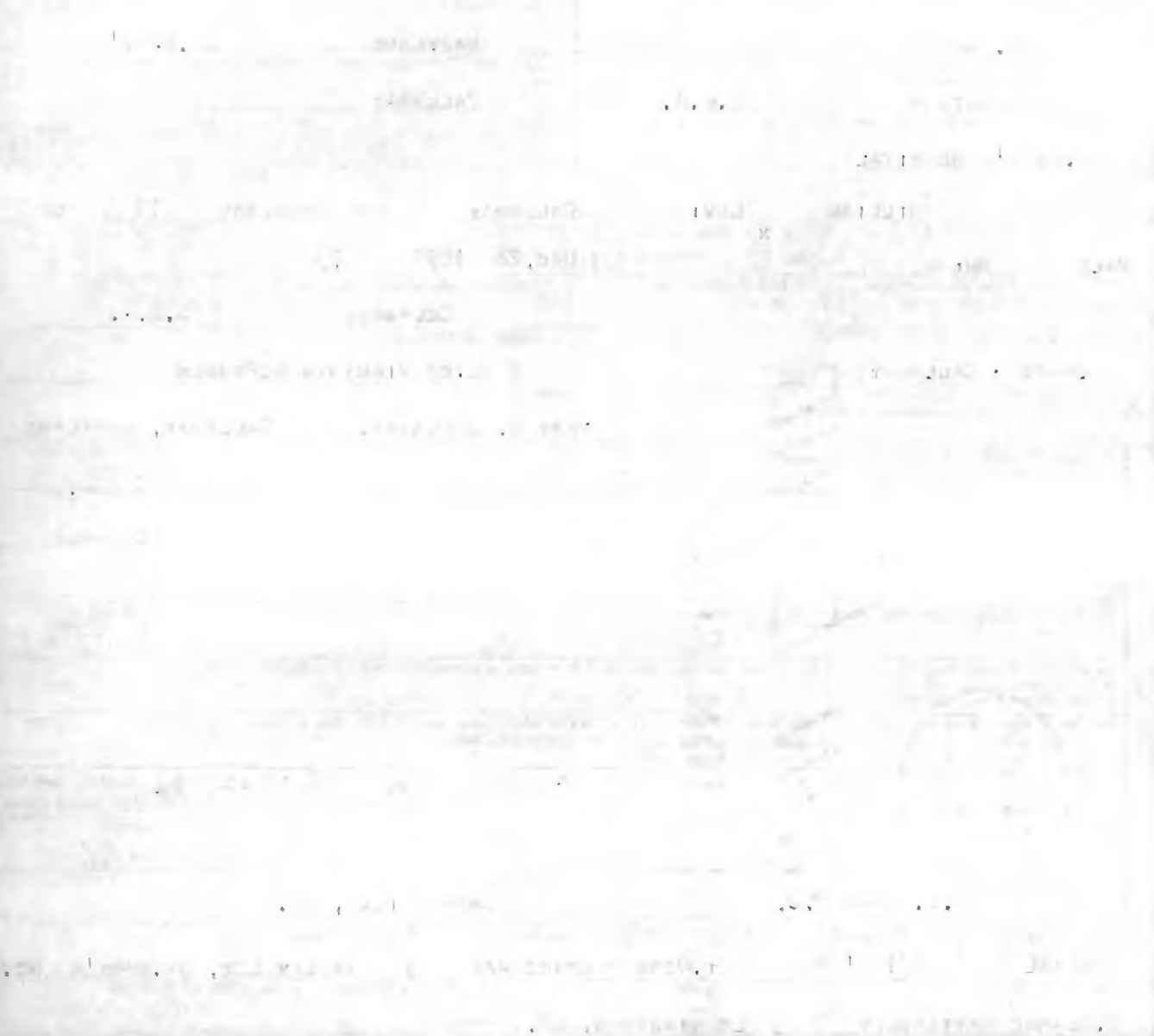
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| 1. PLACE OF DEATH a. COUNTY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE | | b. COUNTY | |
| St. Mary's | | Leonardtown | | D.O.A. | | Maryland | | St. Mary's | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | St. Mary's Hospital | | d. STREET ADDRESS | | Callaway | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | | Last | | 4. DATE OF DEATH Month | |
| William | | Levi | | Callaway | | February | | 13 1966 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) yrs. | |
| Male | | White | | | | Dec. 28 1890 | | 75 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | IF UNDER 1 YEAR Months Days Hours Min. | |
| | | | | Delaware | | U.S.A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| James H Callaway | | Alice Virginia McFadden | | | | | | Mary O. Callaway, Callaway, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 years</u> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | | | | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>October 12, 1966</u> , to <u>Feb 13, 1966</u> , that (I) (we) saw the deceased alive on <u>Feb 12, 1966</u> , and that death occurred at <u>9:30 A.M.</u> from causes and on the date stated above | | 22a. SIGNATURE <u>P.J. Bean M.D.</u> | | 22b. DATE SIGNED <u>Feb 14/66</u> | | 22c. PHYSICIAN'S NAME (Type) P.J. BEAN M.D. | | 22d. ADDRESS GREAT MILLS, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2/15/66 | | 23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE EPISCOPAL | | 23d. LOCATION (City or Town) (County) (State) Valley Lee, St. Mary's MD. | | 25a. REC'D BY REGISTRAR DATE FEB 17 1966 | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | 25c. ADDRESS LEONARDTOWN, MD. | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

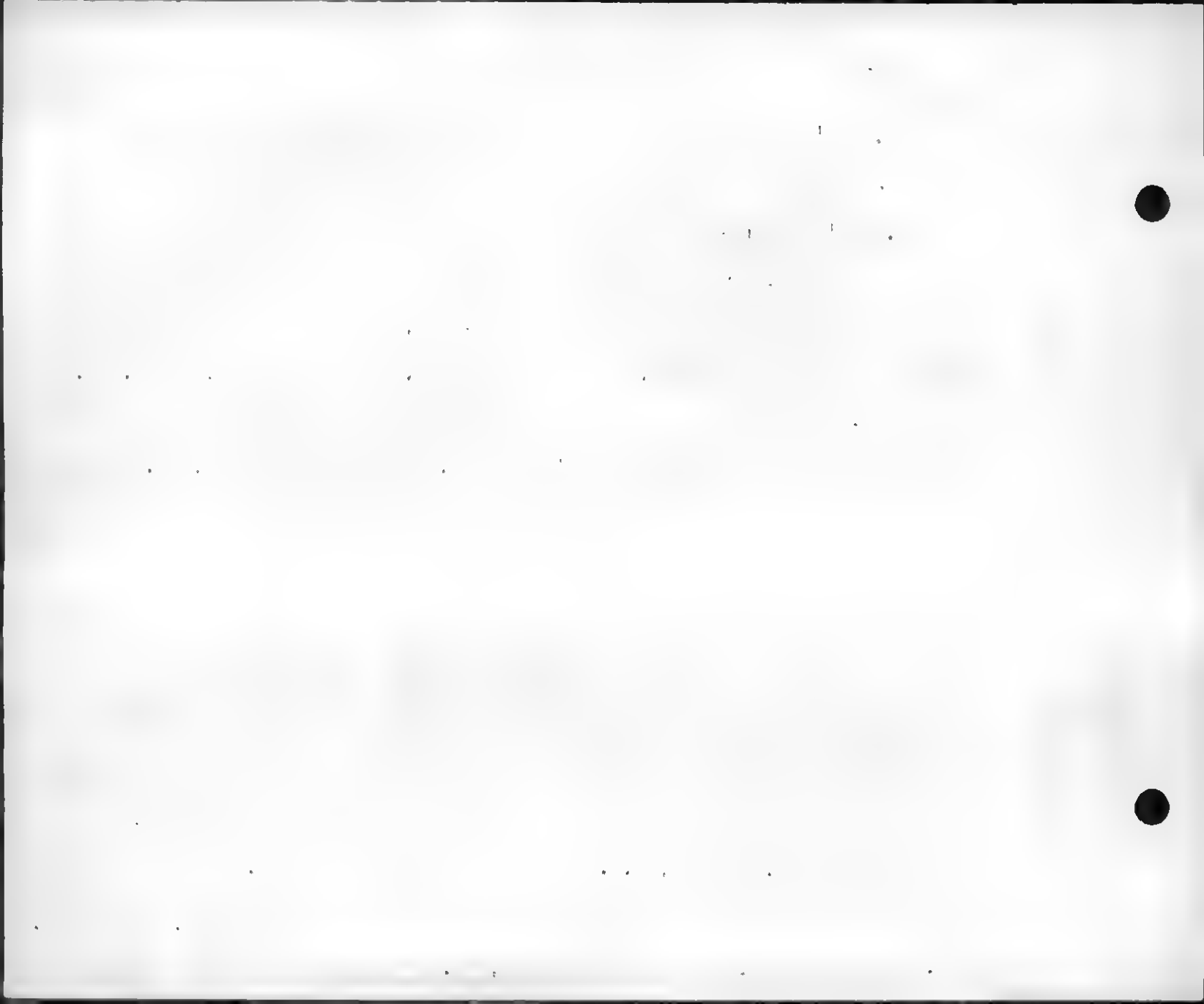
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| 1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | c. LENGTH OF STAY in 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL | | d. STREET ADDRESS OAKLEY | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First WILLIAM Middle ALBERT Last COUNTISS | | 4. DATE OF DEATH Month FEBRUARY Day 13 Year 1966 | |
| 5. SEX MALE | 6. COLOR OR RACE COLORED | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 17, 1921 |
| 9. AGE (In years lost birthday) 44 yrs | | 10. IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min 44 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARMING | |
| 11 BIRTHPLACE (County & State or foreign country) ST. MARY'S MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH I. COUNTISS | | 14. MOTHER'S MAIDEN NAME MARY ELIZABETH LEE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 215-34-3381 | |
| 17. INFORMANT MARY E. THOMAS | | Address OAKLEY, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) cachexia and cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) metastatic carcinoma of lung DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE John F. Fenwick | | 22b. DATE SIGNED 2-14-66 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK, M.D. | | 22d. ADDRESS LEONARDTOWN, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2/17/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART | | 23d. LOCATION (City or Town) (County) (State) BUSHWOOD ST. MARY'S Md. | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | 25a. REC'D BY REGISTRAR DATE FEB 17 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and must be filed within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02810

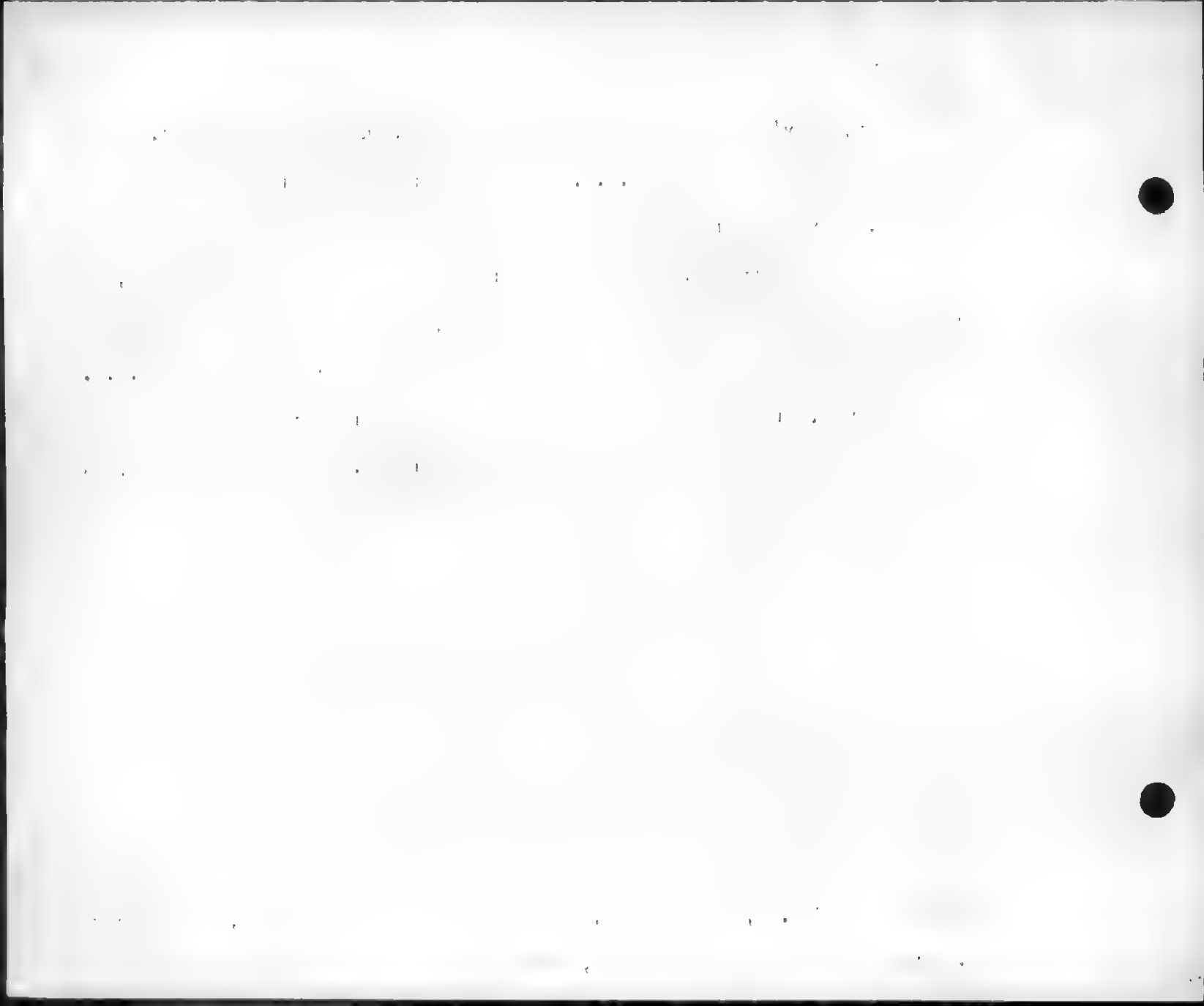
02833

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|------------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | c. LENGTH OF STAY IN 1b D.O.A. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital | | | | d. STREET ADDRESS RURAL PINEY POINT | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last PAUL KKKM LEON DICKENS | | | | 4. DATE OF DEATH Month Day Year FEBRUARY 20, 1966 | | | |
| 5. SEX MALE | 6. COLOR OR RACE COLORED | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 5, 1940 | | 9. AGE (In years last birthday) 25 yrs | | 10. UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY CLEANING | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME VIRGIL A. DICKENS | | | | 14. MOTHER'S MAIDEN NAME CATHERINE BRISCOE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO | | 17. INFORMANT MRS. CATHERINE B. DICKENS PINEY POINT, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 9195 IMMEDIATE CAUSE (a) Gun Shot DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Immediate |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot while in flight | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 1:35 p.m. 2-20 1966 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Park Avenue | | 20f. (City or town) (County) (State) Leonardtown St. Mary's Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE WILLIAM D. BOYD MD | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | 22. DATE SIGNED 2/21/66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF FEB. 23, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery | | 23d. LOCATION (City or Town) (County) (State) Valley Lee, Maryland | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | | | ADDRESS LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR FEB 24 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

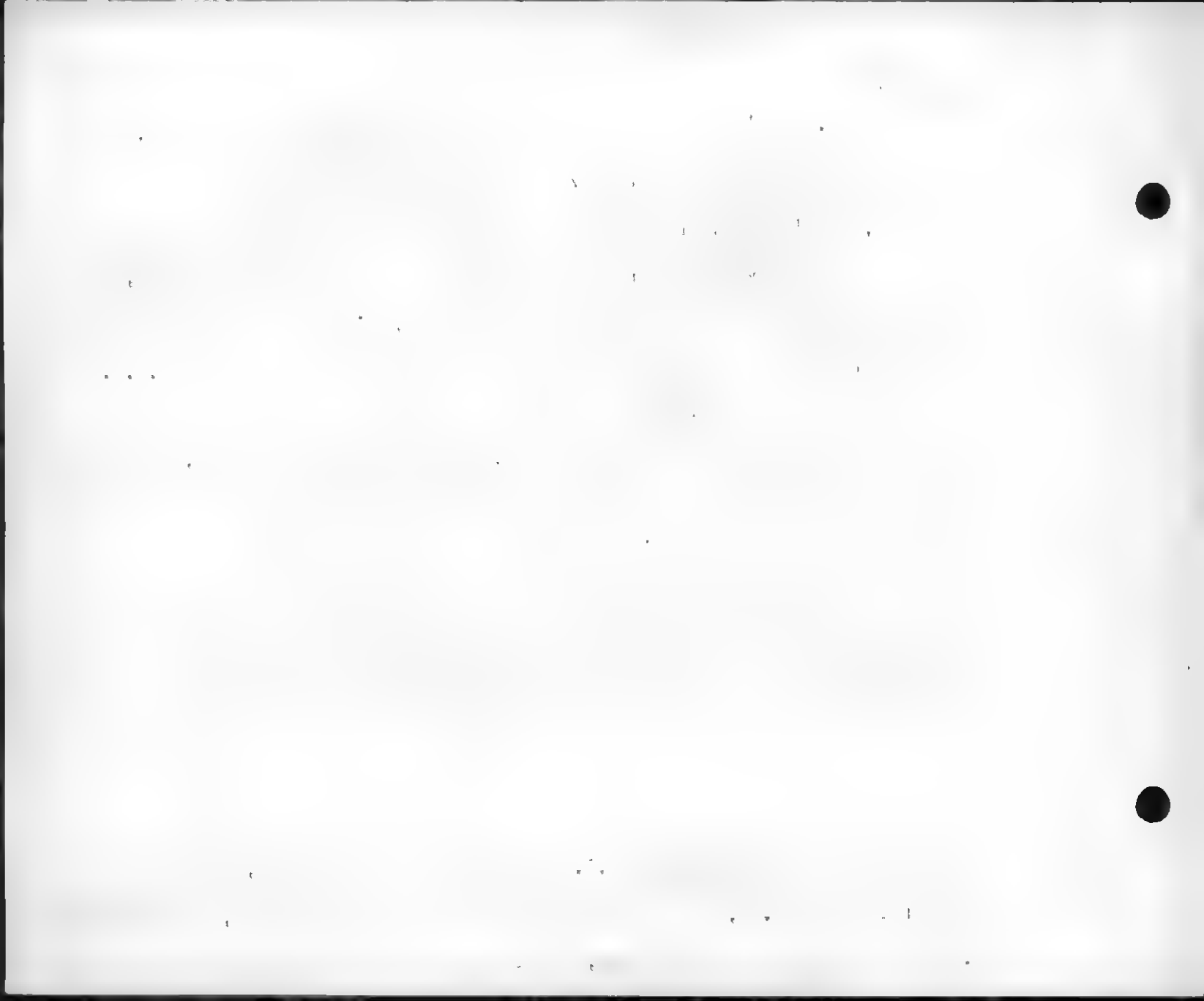
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|-----------------------------------|--|---|
| 02840 | | 02811 | |
| 1 PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY St. Mary's | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | c LENGTH OF STAY in 1b 12 DAYS | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last DYSON | | 4. DATE OF DEATH Month FEBRUARY Day 10 Year 1966 | |
| 5 SEX FEMALE | 6 COLOR OR RACE COLORED | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH JUNE 14, 1884 |
| 9 AGE (In years last birthday) 81 yrs | | 10 IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b KIND OF BUSINESS OR INDUSTRY HOME | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN | | 14. MOTHER'S MAIDEN NAME MARY SHAW | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO NONE | |
| 17. INFORMANT CHARLES HENRY DYSON | | Address AVENUE, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 30 min | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a SIGNATURE John T. Fenwick | | 22b. DATE SIGNED 2-14-66 | |
| 22c PHYSICIAN'S NAME (Type) CHARLES GREENWELL M.D. | | 22d. ADDRESS LEONARDTOWN, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF FEB. 14, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY | | 23d. LOCATION (City or Town) (County) (State) BUSHWOOD, MARYLAND | |
| 24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | 25a. REC'D BY REGISTRAR LEONARDTOWN, MARYLAND | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | 25c. DATE FEB 17 1966 | |



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02841

02812

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE Maryland c. COUNTY St. Marys | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN ID DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Marys Hospital | | e. STREET ADDRESS US Naval Air Station | |
| 3. NAME OF DECEASED (Type or print) FREDERICK (n) | | 4. DATE OF DEATH February 11 19 66 | |
| 5. SEX male | 6. COLOR OR RACE negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 4, 1930 |
| 9. AGE (In years last birthday) 35 yrs. | | 10. BIRTHPLACE (State or foreign country) Youngstown, Ohio | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired HM 1 | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert J. Faison | | 14. MOTHER'S MAIDEN NAME Frances Stubblefield (dec) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1948-1961 | | 16. SOCIAL SECURITY NO. 301 22 0941 | |
| 17. INFORMANT US NAS | | 18. ADDRESS Patuxent River, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Enter Thoracic Hemorrhage CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) auto accident | |
| 20c. TIME OF INJURY Month, Day, Year 2-11 1966 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 235 | | 20f. (City or town) Mechanicville (County) St Mary (State) MD | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Wm D. Boyd | | 22. DATE SIGNED 2/11/66 | |
| EXAMINER'S NAME (Type) Wm D. Boyd, M.D. | | 23. LOCATION (City, town or county) Leonardtown, Maryland | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF Transit & burial 2/12/66 | | 23c. NAME OF CEMETERY OR CREMATORY Youngstown, Ohio | |
| 24. SIGNATURE OF REGISTRAR P.B. Robinson - Leonardtown, Maryland | | 25a. REC'D BY REGISTRAR FEB 14 1966 25b. REGISTRAR'S SIGNATURE John Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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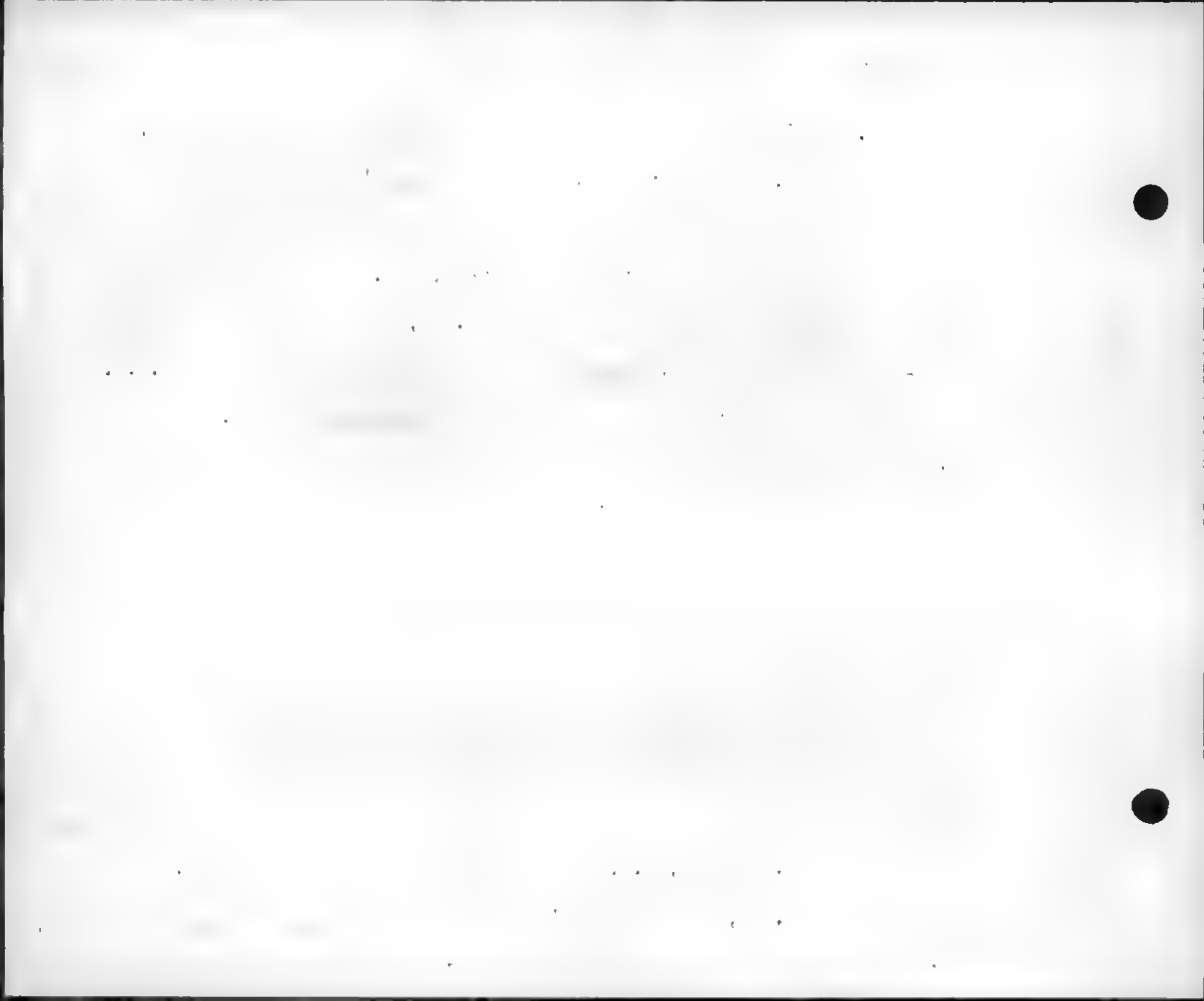
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02842

02814

| | | | | | |
|--|---|--|---|--|---|
| 1 PLACE OF DEATH a COUNTY ST. MARY'S MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ST. MARY'S | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN, MEDLEY'S NECK | | | c LENGTH OF STAY IN 1b LIFE | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last CLARENCE ALFRED GODDARD, SNR. | | | 4 DATE OF DEATH Month Day Year FEBRUARY 13 19 66 | | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Nov. 23, 1889 | 9 AGE (In years last birthday) 76 yrs | IF UNDER 1 YEAR Months Days Hours Min |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b KIND OF BUSINESS OR INDUSTRY FARMING | | 11 BIRTHPLACE (County & State or foreign country) MARYLAND | |
| 13 FATHER'S NAME WILLIAM SAMUEL GODDARD | | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | | 16. SOCIAL SECURITY NO | | 17 INFORMANT Address MARY J GODDARD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) myocardial infarction and failure DUE TO (b) arteriosclerotic heart Disease DUE TO (c) Emphysema Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on _____ M, from causes and on the date stated above. | | | | | |
| 22a SIGNATURE John F. Fenwick | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b DATE SIGNED 2-14-66 | | |
| 22c PHYSICIAN'S NAME (Type) JOHN F. FENWICK, M.D. | | 22d ADDRESS LEONARDTOWN, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b DATE THEREOF FEB. 16, 1966 | 23c NAME OF CEMETERY OR CREMATORY OUR LADY'S CHAPEL | 23d LOCATION (City or Town) (County) (State) MEDLEY'S NECK MD. | | |
| 24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | ADDRESS LEONARDTOWN, MD. | 25a REC'D BY REGISTRAR DATE FEB 17 1966 | 25b REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

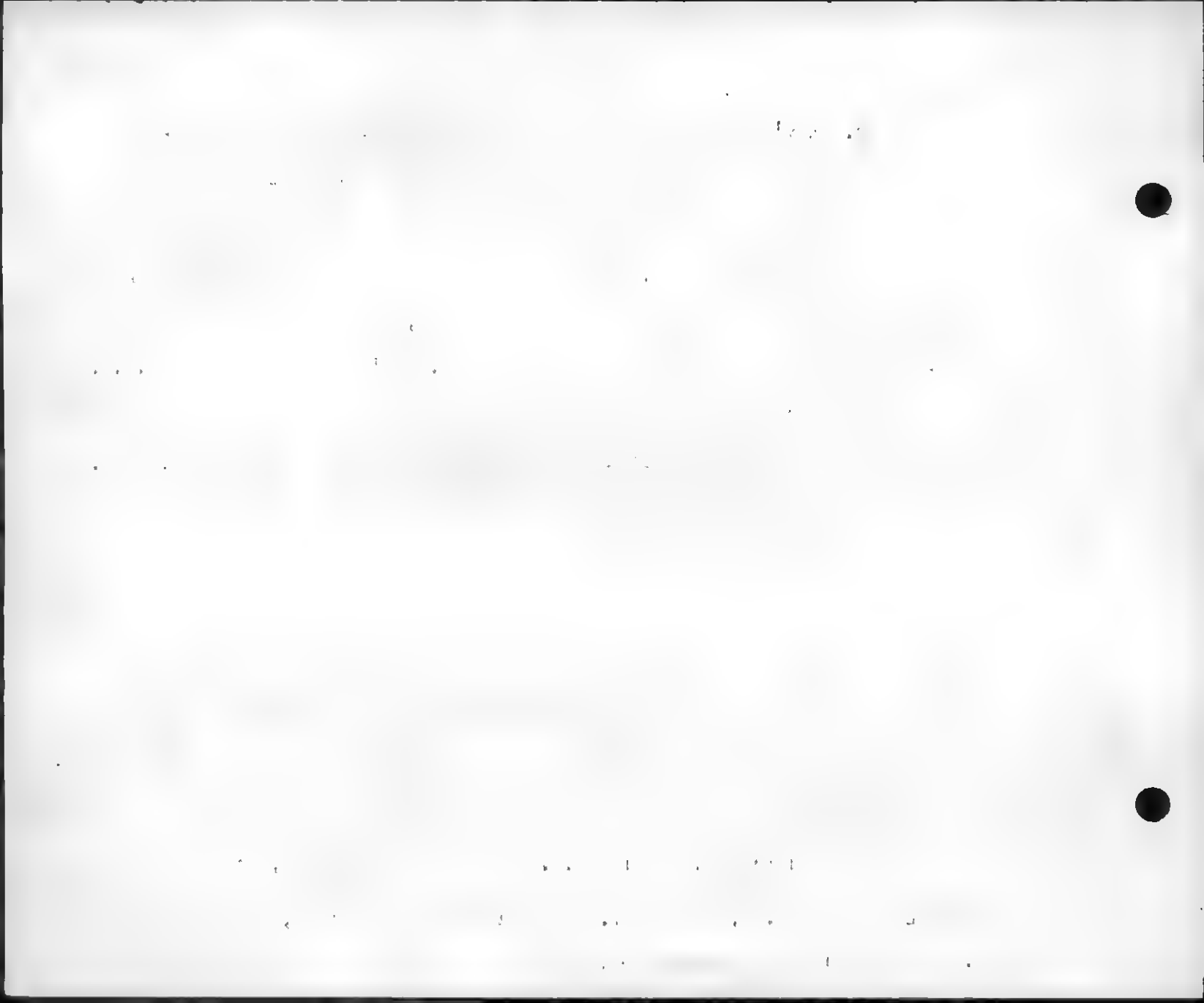
02843

02816

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PARK HALL | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PARK HALL | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle IGNATIUS Last GUNN | | 4. DATE OF DEATH Month FEBRUARY Day 22 Year 1966 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 12, 1898 |
| 9. AGE (In years last birthday) 67 yrs | | 10. UNDER 1 YEAR Months 6 Days 7 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY STATE | |
| 11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WARREN GUNN | | 14. MOTHER'S MAIDEN NAME LUCY GANT | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-18-0378 | |
| 17. INFORMANT WARREN GUNN | | Address 310 E MECHANIC ST., PHIL. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 mo. 25 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 19 to Feb 22, 1966 that (I) (we) last saw the deceased alive on Feb 20, 1966 , and that death occurred at 6A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE W.H. Patrick | | 22b. DATE SIGNED 2-24-66 | |
| 22c. PHYSICIAN'S NAME (Type) WILLIAM H. PATRICK M.D. | | 22d. ADDRESS LEXINGTON PARK, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF FEB. 26, 1966 | 23c. NAME OF CEMETERY OR CREMATORY ST. PETER CLAVERS | 23d. LOCATION (City or Town) (County) (State) RIDGE, MARYLAND |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | 25a. REC'D BY REGISTRAR LEONARDTOWN, MARYLAND | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE FEB 25 1966 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

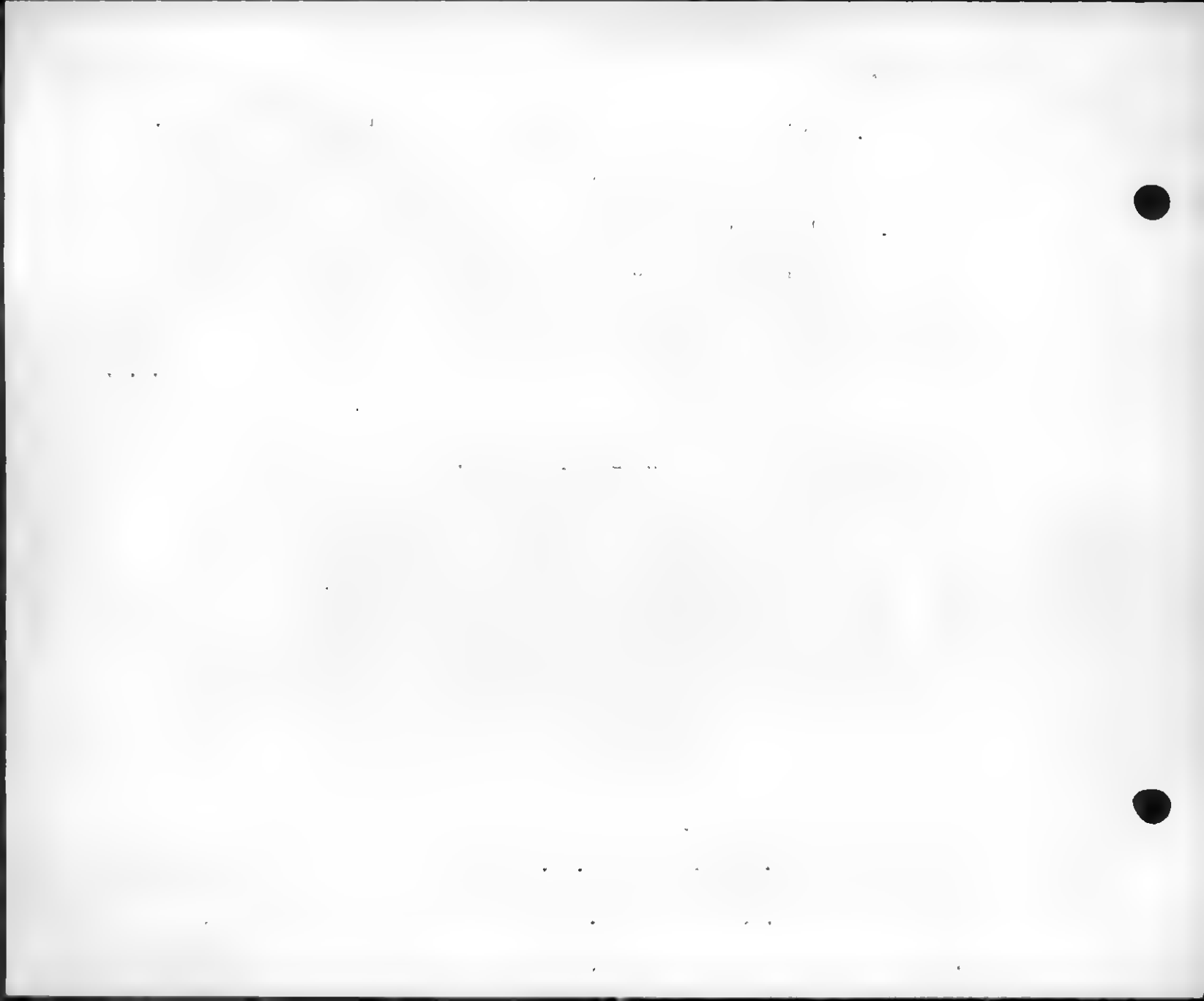
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02244

CERTIFICATE OF DEATH

02817

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ST. MARY'S | | | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | c LENGTH OF STAY IN 1b 3 DAYS | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CALIFORNIA | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL | | | | d STREET ADDRESS | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last PIERRE CYPRIEN LAVOIE | | | | 4 DATE OF DEATH Month Day Year FEBRUARY 1, 1966 | | | | | |
| 5 SEX MALE | | 6 COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 1881 | | | |
| 9 AGE (In years lost birthday) 84 yrs | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS Hours Min. | | | | | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) CANADA | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13 FATHER'S NAME ? ? | | | | 14. MOTHER'S MAIDEN NAME ? ? | | | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16 SOCIAL SECURITY NO 265-01-8192A | | 17. INFORMANT OMAR A. LAVOIE | | | Address ANNAPOLIS, MARYLAND | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c) Circulation of Heart | | | | | | | INTERVAL BETWEEN ONSET AND DEATH days yr | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Artery Disease | | | | | | | 19 WAS A TORSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | | |
| 21. I certify that (1) (this hospital) attended the deceased from 1/1, 1966 to 2/1, 1966 , that (1) (last) saw the deceased alive on 2/1, 1966 , and that death occurred at 10:20 PM , from causes and on the date stated above | | | | | | | | | |
| 22a. SIGNATURE James P. Jarboe M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 2/4/66 | | | | |
| 22c PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D. | | | 22d. ADDRESS GREAT MILLS, MARYLAND | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE THEREOF FEB. 4, 1966 | | 23c NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY | | 23d LOCATION (City or Town) (County) (State) HOLLYWOOD, MARYLAND | | | |
| 24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | | | ADDRESS LEONARDTOWN, MARYLAND | | 25a REC'D BY REGISTRAR DATE FEB 10 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

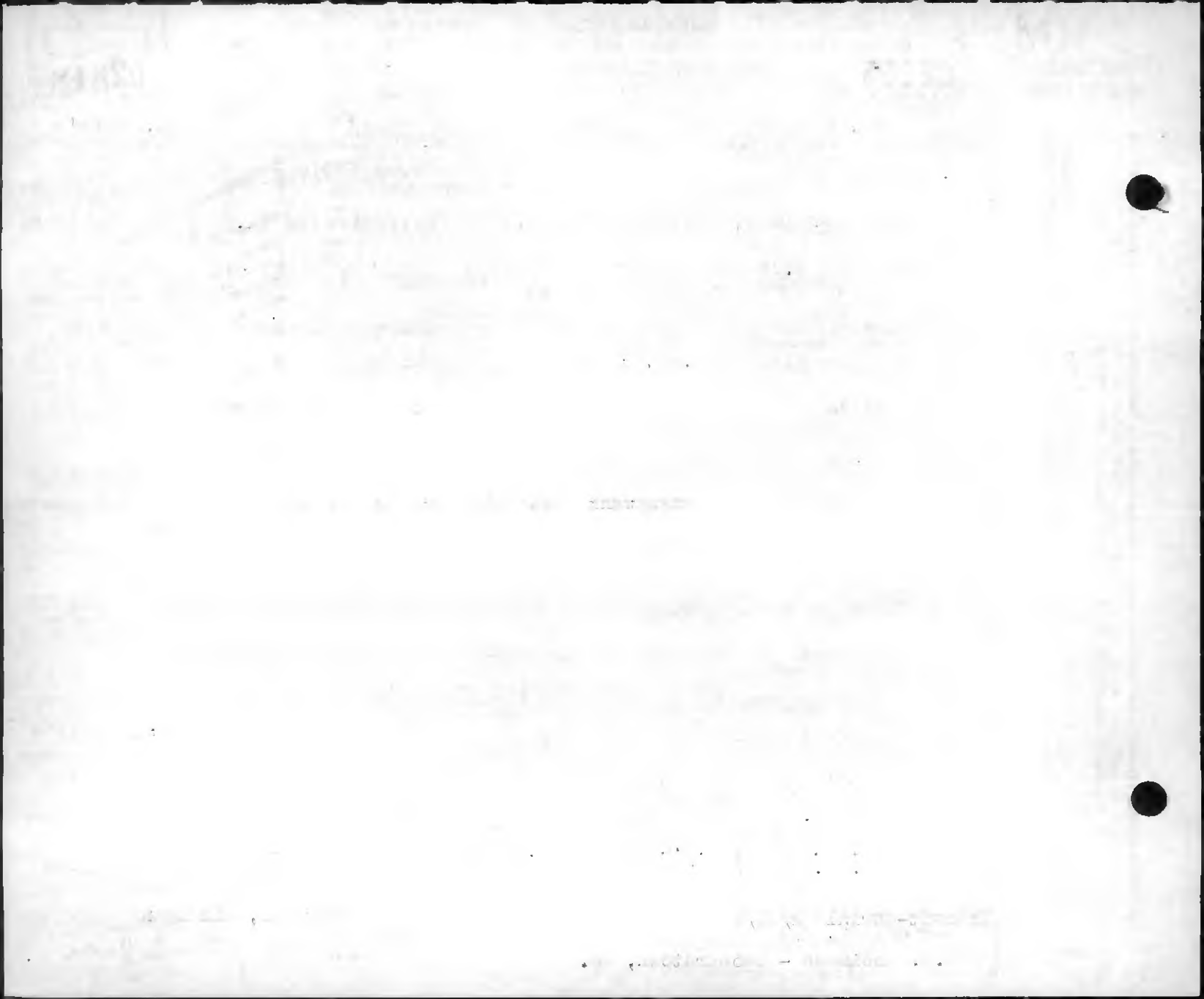
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02845
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02818

| | | | |
|---|-------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Michigan b. COUNTY Farwell | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River Farwell | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital, NAS, PAXRIV, Md. | | d. STREET ADDRESS RR #1 NAS/Barracks/412/ | |
| 3. NAME OF DECEASED (Type or print) First Richard "L" Middle Wilds Last | | 4. DATE OF DEATH February 21 1966 | |
| 5. SEX Male | 6. COLOR OR RACE Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-22-47 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman Apprentice | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy | 11. BIRTHPLACE (State or foreign country) Michigan |
| 13. FATHER'S NAME James Wilds | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. Aug 65-Feb 66 20184719 | 17. INFORMANT Official Navy Records |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning Extensive 3rd degree burns 9173 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Scalding DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH immediate immediate |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell into steampit reservoir | |
| 20c. TIME OF INJURY Month, Day, Year Hour 4:00 p.m. 2-21 19 66 | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shop |
| 20f. (City or town) Patuxent River St, Mary's | | 20g. (County) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE W. D. BOYD, M. D. EXAMINER'S NAME (Type) G. O. GARR, NAS PAX RIV MD | | 22. DATE SIGNED 2-21-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Transit Burial | | 23b. DATE THEREOF 2/23/66 | 23c. NAME OF CEMETERY OR CREMATORY Farwell, Michigan |
| 24. FUNERAL DIRECTOR P.B. Robinson - Leonardtown, Md. | | 25. REC'D BY REGISTRAR FEB 25 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02846

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02819

| | | | | | | | | |
|--|--|--|--|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | c. LENGTH OF STAY IN 1b 3 HRS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE, 18-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last DONALD SCOTT WOOD | | | | 4. DATE OF DEATH Month Day Year FEBRUARY 12, 19 66 | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH APRIL 5, 1950 | | |
| 9. AGE (In years last birthday) yrs 15 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME FRANCIS X. WOOD | | | | 14. MOTHER'S MAIDEN NAME NELLIE B. BUCKLER | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address FRANCIS X. WOOD MECHANICSVILLE, MARYLAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 8254 IMMEDIATE CAUSE (a) Enter Thoracic Hemorrhage DUE TO (b) 1 1/2 hr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto accident | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 5:40 p.m. 2-12 1966 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RT 236 | | 20f. (City or town) (County) (State) Laurel Grove St Mary Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE W.D. Boyd M.D. EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | | | |
| 22. DATE SIGNED 2/14/66 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF FEB. 15, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPHS CEMETERY | | 23d. LOCATION (City or Town) (County) (State) MORGANZA, MARYLAND | | |
| 24. FUNERAL DIRECTOR ADDRESS W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | 25a. REC'D BY REGISTRAR DATE FEB 17 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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EDWARDSVILLE

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